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ABSTRACT

In contrast to Freud's later and revised view of the etiology of hysterical, or dissociative, symptoms, it is now known that real, and not fantasized, sexual experiences in childhood are experienced in disociative symptomatology. It is useful to understand that incest involves both traumatic events, that is, incidents of sexual violation per se, as well as a larger traumatic developmental context. This context is fraught with invalidation of the child's experience, irreconcilable messages by caretakers, the ongoing threat of further abuse, boundary violations, and severe disruptions in the parent/child attachment process. Given the child's inborn and age-appropriate ability to dissociate, these conditions dispose the child towards developing a dissociative disorder. The adult survivor employs dissociation to manage the memory of childhood abuse. Therapists must be attuned to the dynamics of incestuous families and the ways in which they foster dissociative defenses. This awareness helps therapists appreciate the adaptive nature of clients' dissociation, and also guides interventions towards what will be healing and not re-traumatizing. In the therapy relationship a detailed examination of the client's dissociative process provides clues as to how early abuse scenarios are replayed and re-experienced in the transference, and which need areas have been disrupted by trauma and require attention in the treatment. (ABL)

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Symposium: "Dissociative Alterations of Consciousness and Trauma"

Dissociative Reactions to Incest

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DISSOCIATION AND INCEST

We're here today examining the relationship between trauma and dissociation, which can be defined most simply as the severing of the association between one mental content and another. This presentation will focus on the trauma engendered by incest. First, I will discuss conditions in incestuous families that precipitate and reinforce dissociation. Then, I will describe a variety of dissociative responses that the clinician observes, and how these responses inform us about the client, their adaptation to trauma, and its manifestation within the therapy relationship. The presentation will consist of an overview of aspects of incest and dissociation based upon research and my experience as a therapist in a clinic specializing in the treatment of survivors of various types of trauma. My conclusions regarding incest are derived primarily from adult female survivors of relatively severe childhood sex abuse by adult caretakers. While I want to acknowledge the male survivor, for convenience and in agreement with prevalence studies, I will refer to incest victims in the feminine.

In contrast to Freud's later and revised view of the etiology of hysterical, or dissociative, symptoms, we now know that real, and not fantasized, sexual experiences in childhood are implicated in dissociative symptomatology. In large-scale studies such as those reviewed by Braun (1990), it has been shown that 95 to 98% of patients with Multiple Personality Disorder were victims of severe child

abuse, particularly incest. Briere & Runtz (1988) have demonstrated that even nonclinical samples of adults sexually abused as children report higher levels of dissociation than their non-abused cohorts. This connection between sexual abuse and dissociation is clear to the clinician who works with abuse survivors, and one must often work 'backward' from manifest dissociative symptoms to the underlying abuse memories.

What is it, then, about childhood sexual abuse, and incest in particular, that fosters both momentary dissociative defenses as well as the enduring dissociative disorders of adulthood? It is useful to understand that incest involves both traumatic events, that is, incidents of sexual violation per se, as well as a larger traumatic developmental context. This context is fraught with invalidation of the child's experience, irreconcilable messages by caretakers, the ongoing threat of further abuse, boundary violations, and severe disruptions in the parent/child attachment process. Given the child's inborn and age-appropriate ability to dissociate, these conditions dispose the child towards developing a dissociative disorder.

When undergoing acts of sexual violation, the child uses dissociation to manage the intolerable fear, pain, and helplessness. This is particularly relevant when the abuse is severe, sadistic, or torturous. Afterwards, the child is generally not consoled, validated, afforded safety or attention to healing. In contrast, she attempts to manage the traumatic experience within a family environment that

perpetuates the use of dissociative defenses, not only through repetition of abusive episodes, but also through the upholding of discordant, irreconcilable views of reality and the self. For example, the child may be encouraged 'not to tell', 'not to know' or threatened into silence. She may be told that she wanted the abuse. Indeed, after a repetitive pattern of abuse has been established, the child may approach such encounters with a sense of resignation and apparent willingness which furthers her sense that she is responsible. There may also be elements of the sexual contacts that are pleasurable or unavailable at other times, such as the physical stimulation or the sense of closeness. Thus, the child holds the irreconcilable messages, 'I wanted this', and 'This hurts and feels wrong'. And since the abuse is hidden in secrecy, yet continues to occur, the child learns both that 'This is hidden and bad', and 'It is acceptable'. The child is torn between the reality of her inner experience and the falsely positive view of the family that is upheld by the parents and to the community.

The child is also unable to integrate the changing and unpredictable behavior of the perpetrator. This caretaker may be intermittently loving, tender, and warm, and at other times be intrusive and hurtful. In the many instances where the caretaker is dissociative, these changes in mood and behavior may be especially rapid and non-continuous. Thus, there is an irreconcilable pairing of love and violation in the behavior of the perpetrator, a trusted caretaker who is also willfully abusive.

Unable to integrate such discrepant cognitions and their associated affects, the child is encouraged to maintain them as separate, compartmentalized psychological entities though dissociation. The child may dissociate the traumatic experiences as 'not me' through a fragmentation of identity, as in the formation of alter personalities, or split internal representations of self and other into 'good' and 'bad'. She may come to believe simply that she is bad, a belief that also allows her to maintain an idealized view of her caretakers.

Acts of abuse represent a withdrawal by the caretaker, who divests the child of her personhood and uses her solely as an object of gratification. Barach (1991) asserts that while dissociation is clearly consequent to active abuse, more important in the etiology of dissociative disorders like MPD are disruptions in the normal attachment process due to preoccupied and withdrawn parenting. Using Bowlby's theory of attachment, he describes how a child naturally yearns for soothing by her mother after a traumatic experience. However, if the mother has repeatedly abandoned the child through neglect, indifference, or her own dissociation, the child comes to detach and actively turn away from her. This detachment constitutes a dissociation of internal and external cues that would normally elicit attachment behavior and allow the experience of bonding between mother and child. The child's reactive detachment then sets the stage for the use of dissociative defenses in response to real and anticipated abuses and abandonments in later relationships.

I have described some of the characteristics of abuse by incest that both precipitate and perpetuate dissociation. Let me turn now to discussing the ways in which dissociation may be observed by the clinician, and its importance in understanding the client and the therapy relationship.

As a therapist, it is important to determine <u>if</u> a person is dissociative, and to what extent dissociation is disruptive in their life. Beyond this, it is also necessary to identify and understand the specific nature of their dissociative experiences. There exist endless individual manifestations of dissociative defenses, each as unique as the person for whom they operate. The therapist must determine what a client's dissociation reveals about the nature of their traumatic experiences and their subsequent adaptation.

Incest survivors can sometimes tell you exactly how they dissociated during episodes of abuse. Many survivors dissociated in ways that afforded them a sense of perceived protection, or the ability to hide from perpetrators. For example, a client may talk about becoming very small and going down into the rug, or fading into the wall. Others describe attempts to become invisible, shrink away, or 'play dead' by lying perfectly still. Still other survivors talk about having left their bodies during the abuse in order to escape physical and emotional pain. Clients speak of ascending above the abuse scene, watching and feeling sorry for the unfortunate child who is suffering below.

Some victims evolved other personalities or ego states to help them cope as the abuse occurred. According to Kluft (1992), these alters develop through subjective personification of self-states, imaginative companionship and involvment with media characters, and introjection, identification, and internalization of significant others. The alters offer anaethesia by taking or distributing the pain, or give companionship and soothing, for example by leading the child to imagined places of safety away from the abuse.

The adult survivor employs dissociation to manage the memory of the childhood abuse. These memories have several components. First, traumatic experiences are stored as sensory images, including the visual image of the trauma, as well as related sounds and smells. Bodily sensations can be considered a unique class of sensory memory, given that sexual abuse is so strongly a physical experience. Memories also have affective components and verbal components. Verbal memory includes the internal narrative of 'what happened when', as well as the words spoken during and about the experience. These three components of memory can be dissociated from current consciousness and one from another, much like Braun's (1989) BASK model of the dissociative dividing lines between behavior, affect, sensation, and knowledge. For example, a survivor may relate a coherent and detailed story of her abuse, but do so in a flat tone devoid of feeling. Here, the affective memory is dissociated while the verbal memory is available. Similarly, a client may have intense body

sensations derived from abuse without yet having other indications that she was abused. Finally, some clients dissociate to states of numbness or nothingness, describing states or alters with names like 'White', or 'Neutral'. These states exclude all aspects of memory, but apparently serve mainly to dissociate affect.

It also appears that memories are stored within an interpersonal context. It is common for an adult survivor to repeatedly reenact the interpersonal dynamics of her childhood abuse, even prior to remembering the abuse itself. The therapist begins to learn about the nature and consequences of the abuse through observing transferential and countertransferential responses within the therapy relationship. Dissociation during therapy is informative as to the interpersonal threat being experienced with the therapist. As opposed to other types of trauma, the relational trigger to dissociate may be particularly prevalent for survivors of incest, since incest is a trauma embedded within a lengthy, formative, intimate familial relationship that is also mirrored in the therapy process.

When a client dissociates in the therapist's office, it is useful to explore the nature of the dissociation, and to wonder how she might be experiencing a threat in relation to the therapist. Questions like, "Where did you go?", "What just happened", or "What's happening now?" allow for a detailed examination of the client's dissociative process. For example, a client of mine entered into a dissociative daze, staring blankly towards my desk. When asked about it, she revealed that she was

feeling compelled to grab a pen from the desk and wound herself with it. This led to an exploration of her reasons for wanting to injure herself using an object belonging to me.

In addition to reeenactments in the transference, one can conceptualize the psychological injuries suffered by an incest survivor as disruptions to interpersonal need gratification and the expectation of such gratification. According to McCann & Pearlman (1990), psychological needs affected by trauma include those for safety, trust and dependency, esteem for self and others, control, connection to others, and a framework for understanding why things are as they are. These needs develop partly through processes of gratification and frustration in formative interpersonal relationships. If these relationships are traumatizing, as in incest, then movement toward need gratification in relation to others will be associated with traumatic memories, affects, and cognitions, and will thereby be prone to disavowal through dissociation. The dissociation will be manifested interpersonally in the therapy relationship. For example, a client who dissociatively becomes very small and shrinks into the rug may be demonstrating a perceived threat to her safety from the therapist, and/or flashbacks to earlier traumas. Here, the dissociative reaction informs the clinician that the client's safety needs are severely disrupted, and that helping her better meet these needs in the present is a necessary part of the treatment. The clinician must listen for the particular areas of need disruption that relate to

a given traumatic memory.

A common and particularly deep-seated injury to need gratification is in the area of trust and dependency. Since the incest survivor has historically experienced that depending on others results in pain and betrayal, she learns to dissociate the affects and cognitions related to these yearnings. The dissociation may take the form of an ongoing internal sequestering of dependency strivings, as when encapsulated within a child identity. Often this dependent child is viewed with scorn by other facets of the self. In the therapy relationship, the client is torn between moving towards and away from the potentially gratifying therapist. As she approaches the therapist, the risk of harm, betrayal and abandonment increases. To protect herself from this perceived threat, she may become increasingly dissociative in order to disavow the problematic dependency needs. An example is a woman who was dealing with memories of a childhood rape by her father. This rape constituted a tremendous abandonment by the father, and as the memory surfaced the client became increasingly dissociative and detached in therapy. She also became quite suicidal, and we later learned that she was needing to know if she could count on me to actively intervene to keep her safe, or if I would instead be indifferent and allow her to die, which would recount the abandonment of her rape experience. Her dissociative withdrawal in the therapy relationship enabled us to explore first-hand her profound isolation and despair within her family of origin.

A survivor who has dissociatively disavowed her dependency strivings often presents with high needs for control and independence. When the dissociation is severe, there may exist alters or ego states where power and control are primary characteristics, and others that are dependent and childlike.

If a client relies heavily upon dissociation in daily functioning, and demonstrates a relative inability to manage affect and console herself in other ways, then she is not yet adequately prepared to deal with abuse memories. Here the therapy must focus first on developing constructive ways to self-soothe, including the ability to tolerate being alone, regulate self-loathing, and maintain a constant internal representation of others. These capacities of the self normally develop in the first several years of life, largely out of healthy attachment to caretakers. If the attachment process is interupted by trauma and/or the mother's failure to respond, then the ability to self-soothe will be compromised. In the therapy relationship, the client will have difficulty maintaining an attachment to the therapist that affords soothing and consolation. This inability may be particularly conspicuous as traumatic memories are emerging. For example, a client was referred to me because her prior therapist was moving. After a visit to her parents, who had abused her as a child, she became increasingly dissociative. In addition, the departing therapist had notified her that he would be unable to have a termination session with her as expected. She described having

'exited' to a state referred to as 'numbness', 'limbo', and 'like a zombie'. In this state there was no pain except for the fear of the profound isolation. I believe that after the visit to her parents and the abandonment by the prior therapist, she became detached from people and the world. I suspect that this state was reminiscent of her sense of detachment and dissociation after being traumatized by her parents as a child, and she now needed alternative ways to console herself and maintain interpersonal connectedness.

To conclude, as therapists we must be attuned to the dynamics of incestuous families and the ways in which they foster dissociative defenses. This awareness helps us appreciate the adaptive nature of our clients' dissociation, and also guides our interventions towards what will be healing and not retraumatizing. In the therapy relationship, a detailed examination of the client's dissociative process provides us with clues as to how early abuse scenarios are replayed and reexperienced in the transference, and which need areas have been disrupted by trauma and require attention in the treatment.

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